*A Consumer's Guide to:*

# Health Care Coverage

*Understanding Your Health Insurance Options*

Washington State
Office of the
Insurance Commissioner

www.insurance.wa.gov

# Dear Health Care Consumer:

In the past few years, the face of health care in Washington State (and across the country) has changed dramatically. Many of these changes directly affect your rights and options as a consumer of health insurance and, in some cases, may affect your access to coverage as well as care.

To help you keep up with the constant changes in the individual health insurance market, understand your rights and options, and obtain health care coverage that meets your needs, my staff has prepared this consumer guide. It will help you understand:

- what kind of health plan may be best for you and your circumstances;
- how different types of health care plans work, and;
- how to obtain quality care and fair treatment from your health care providers.

I cannot emphasize enough how important it is for consumers to have adequate health insurance. Uninsured people may avoid getting treated for medical conditions that may escalate into major health and financial problems.

If you have insurance questions or concerns, call our Insurance Consumer Hotline at 1-800-562-6900. Our Consumer Advocacy staff includes experts in all lines of insurance (auto, homeowner, life, disability and health) and provides free assistance and education to consumers. Consumer Advocacy also has the authority to investigate formal complaints against insurers and enforce insurance law on behalf of consumers.

For additional help with health insurance issues and health care access, the Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine is a free service of my office. SHIBA HelpLine provides specialized health insurance education, assistance, and advocacy, including individualized counseling regarding your rights and options. To be referred locally for assistance, call our Insurance Consumer Hotline at 1-800-562-6900.

Please let me know how else we can help.

Sincerely,

Mike Kreidler

Mike Kreidler
Washington State Insurance Commissioner

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# Section 1

## Defining your needs and eligibility

Health care coverage is always evolving, and health insurance and health care access issues are increasingly complex in today's market. You must be sure that the health care system you choose meets your needs.

Different kinds of health coverage plans are available based on your current needs, personal circumstances and financial resources. This section is organized around discovering what kind of policy or plan you may need, are eligible for, and can afford.

Consumers who might need to turn to the individual market to purchase health care coverage include those who do not have insurance through their own employment or that of a spouse or parent. While a large percentage of people do have their primary health coverage through an employer, there is an increasing population of individuals who do not have access to employment-related benefits.

What if your employer's health plan does not meet your needs? Perhaps the plan doesn't cover your spouse or dependents, is too expensive, or you haven't worked long enough in the company to qualify. Or you may have to wait for an "open-enrollment" period (usually the same month each year). In those cases, you may want to look into buying your own individual policy.

### Real-life situations in which entering the individual market for health care coverage may be necessary:

- You just moved to Washington from another state and need insurance.
- You will no longer be covered under your parents' policy.
- The rates for family health insurance through your employer are too high for all of you to be covered. If you continue on your employer's plan, you need coverage for your spouse and/or children.
- Your kids need insurance to play sports at school.
- You work one or more part-time jobs, and none offer benefits.

**Check with your plan administrator** to find out if your employer's plan is subject to Washington State Insurance regulation as described in this guide. Some types of plans, including self-funded and union trust plans, are exempt from state regulation.

# Employment-related coverage

If you are currently employed, you might qualify to purchase the following types of coverage:

## • Group plans

If either you or your spouse are working, you may be able to obtain health benefits through the employer. Unlike those enrolling in an individual plan, if you are enrolling in a group plan you do not have to take the health screen as explained on page 5. Group plans cannot reject you based on health status. For more information, check with the plan's administrator. If you are **self-employed** and have at least one full-time employee, you may be eligible for a small group plan.

## • Professional organizations and association plans

Another kind of group plan is sometimes offered through professional organizations, such as local realty boards or the chamber of commerce. These so-called "association plans" are often accessible to people in a particular industry, professional group, or business association. Additionally, you may be eligible for health insurance through a religious or fraternal organization.

Be sure you fully understand the exact scope of benefits you are purchasing. While association plans are offered statewide, sometimes at very competitive rates, disappointments are common among subscribers who were not aware of a plan's limitations and exclusions.

Association plan subscribers may wish to consider purchasing riders to the basic coverage to ensure a more complete package of benefits. It is also important to get benefit information in writing.

## • COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) was passed in 1986. It provides for availability of health benefits to employees who are terminated or lose medical coverage because their hours are reduced. Group health plans provided by companies with 20 or more employees may be subject to COBRA.

The federal Centers for Medicare and Medicaid Services (CMS), which administer the Medicare program, also publish helpful guides such as *Medicare & You.* Visit them on the Web at: www.medicare.gov or call 1-800-MEDICARE.

**Warning:** If you are enrolled in Medicare Part A (hospital coverage) and you elect COBRA but fail to enroll in Medicare Part B (medical coverage), you may be subject to penalties and to a delay in coverage under Part B when your COBRA expires. This delay in coverage could leave you without medical insurance for up to 16 months, depending on the date your COBRA expires.

If an employee, spouse, or dependent was covered by the group health plan on the day before a qualifying event (see below), then the employee, spouse, or dependent may be eligible to buy continued coverage under the group plan for 18-36 months, depending on the qualifying circumstance.

**A qualifying event for an employee** is reduction in hours or losing a job for reasons other than "gross misconduct."

**A qualifying event for a spouse or dependent** includes reduction in hours or termination of the covered employee (as described above), plus:

- **Divorce** or legal separation from the covered employee
- **Death** of the covered employee
- **Entitlement to Medicare** by the covered employee
- **Loss of** "dependent child status"

Beneficiaries must pay for COBRA coverage themselves. They may be charged up to 102 percent of the total cost of the group plan, which includes the portion usually paid by the employer.

In June 1998, the U.S. Supreme Court ruled that COBRA coverage may not be denied when other group health coverage is present on or before the COBRA election day. An individual who already has other coverage (including Medicare) on or before the date he or she becomes eligible for COBRA may continue that coverage along with COBRA coverage.

But if an individual qualifies for Medicare after qualifying for COBRA coverage, the employer may terminate the COBRA coverage. Not all plans terminate COBRA coverage immediately upon Medicare eligibility, so check with the plan administrator.

Depending on circumstances, dependents may be able to continue COBRA coverage even if the primary employee (ex-employee) becomes Medicare-eligible.

Continuation Coverage is a limited form of COBRA for consumers leaving small employers with 20 or fewer employees.

For more information on COBRA, call the U.S. Department of Labor (DOL) Employee Benefits Security Administration at **1-866-444-3272**, or check with your employer's Human Resource office.

**If you are leaving your job,** divorcing an employed person, or otherwise being separated from an employment-related plan, you should ask the employer if you are eligible for COBRA benefits. COBRA enrollees can continue benefits at their own cost for up to 18 months. Spouses and dependents can continue benefits for 18-36 months, depending on their circumstances.

# Coverage for individuals and families

If you need health insurance and are not eligible for Medicare, there are several kinds of insurance coverage available:

- Individual and family plans from commercial health plans.
- Individual and family plans sponsored by government agencies.

## Commercial health plans

Currently, there are two general types of health insurance policies being sold in Washington state.

1. **Managed care plans**, often known as Health Maintenance Organizations (HMOs).
2. **Fee-for-service** or indemnity plans.

Each type of policy has its pros and cons. Here is how they work:

### • Managed care

Most health insurance sold in Washington state today operates under the principle of managed care. Managed care is a philosophy of providing health care at the most efficient level. Typically, managed care systems limit their subscribers to a specified network of providers, and require subscribers to work with a "gatekeeper" who tries to make sure that patients do not receive inappropriate health services or undergo procedures unnecessarily.

Managed care plans require consumers to obtain their health care from a large organization or network of professionals. You visit a physician you have chosen from among the managed care plan's network of providers.

Managed care systems may differ greatly from one another. Some allow more freedom than others when selecting a personal physician or other specialist. They also may use different systems of "co-payment" (an upfront charge the consumer pays during an office visit). Depending on your personal circumstances, these differences may be important to you. Ask about the features of any plan before you enroll and be sure you understand how they work.

A managed care premium often covers educational/wellness programs and some preventive exams and routine services, along with diagnostic services and treatment. Your fixed monthly premium (if any) pre-pays as much care as is medically necessary.

With managed care, out-of-pocket expenses come in the form of plan-specified co-payments for some services. For services not approved/covered by the plan, you pay the full amount. The plan usually coordinates bills and payments.

### • Fee-for-service/indemnity

Fee-for-service plans allow consumers to act independently in choosing health care professionals and hospitals.

The "fee-for-service" system is a pay-per-visit arrangement. You see any licensed provider you choose when you need a treatment, service or exam. You are billed each time you receive care. Depending on the service, and your insurance coverage, your policy will cover part of the bill or none. Doctors and other providers in individual or group practice are paid by the insurance company for each service (e.g., office visit, tests).

Usually there is a deductible (amount you pay out of your own pocket before your coverage "kicks in"). You are also responsible for coinsurance (a percentage of expenses that you must pay each time a service or treatment is rendered) and any out-of-pocket expenses (the full fees for services not covered by your insurance). How much of these expenses you pay out of pocket depends on the extent of your insurance coverage.

# Health screening and the individual market

## Application requirements

Most people seeking individual coverage will need to complete a standardized health screen questionnaire. This questionnaire is designed to identify the most costly 8 percent of applicants and offer them eligibility through the Washington State Health Insurance Pool (WSHIP), a legislatively created public/private partnership. Premiums for WSHIP coverage are higher than commercial health plans, but WSHIP members can select from fee-for-service or network plans. Either option offers the potential for lowering the cost of health insurance coverage. For information about the health insurance questionnaire, how it is scored and other details about coverage and rates, contact WSHIP directly at 1-800-877-5187 or visit the website at: **www.wship.org.**

## Pre-existing condition waiting periods

Individual plans may have a nine-month waiting period for any condition for which you were treated, or a prudent layperson would have sought advice or treatment, during the previous six months.

If the plan you held just before your application for a new individual plan is equivalent to -- or better than -- the new plan, the carrier must credit the time you were enrolled in that plan toward the waiting period for the pre-existing condition. (For example, if you had nine months of coverage under your immediately preceding plan, your waiting period would be waived. If you had four months coverage, you would have to wait five months for the new insurance to cover a pre-existing condition.)

If you have 18 months of creditable coverage and otherwise qualify as an "eligible individual" under federal law, then insurers may not impose a pre-existing condition waiting period on your coverage.

## Individuals not required to take the health screen

Certain applicants may not be required to fill out the health screen questionnaire when applying for individual insurance. They include applicants:

- ✓ Who will exhaust their COBRA coverage.
- ✓ Who have 24 months of continuous coverage through a small employer.
- ✓ Who have moved out of their existing plan's service area.
- ✓ Who are staying with a primary care doctor who left their existing plan.
- ✓ Who have received a notice regarding the discontinuation of their conversion plan.

**Remember:** You can quickly locate help by calling our toll-free Insurance Consumer Hotline at: **1-800-562-6900.**

# Plans sponsored by state and federal agencies

In general, these plans are meant to help people who cannot afford insurance in the individual market or have very expensive health care needs. Some programs are specifically meant for people who are disabled or who have limited incomes and resources. Often, people are not aware of their eligibility for these programs.

## Basic Health

The state of Washington subsidizes a public health program called Basic Health (BH) for Washington state residents who meet its income guidelines.

BH is a managed care plan sponsored by the state and administered through private insurance carriers. It is a comprehensive health plan, covering prescription drugs, maternity and major medical costs. However, it does not cover eye and hearing exams, artificial limbs or medical equipment such as wheelchairs or back braces. Physical therapy and chiropractic care is limited to specific circumstances. As is typical of managed care, you must use the services with a network of providers in your area. Besides paying a monthly premium, you will have to meet the $150 deductible each year and make a small co-payment each time you visit your health care provider.

People enrolled in BH pay on a sliding scale, with premiums based on income, age, family size, county of residence, and choice of carrier.

BH may be available for children. For more information, see "Coverage for Kids" on page 10.

Benefits, rates and other details are available by calling 1-800-660-9840, or visit the BH website: **www.basichealth.hca.wa.gov.**

## Medicaid

Medicaid is a publicly-funded program that provides health insurance to specific categories of people who meet financial eligibility requirements. Medicaid was created by the federal government and is usually administered by state governments. The federal government (the Centers for Medicare and Medicaid Services [CMS], formerly the Health Care Financing Administration [HCFA]) provides oversight and some funding to Medicaid programs.

In Washington state, Medicaid programs are administered by the Medical Assistance Administration (MAA) of the Department of Social and Health Services (DSHS). These programs are offered through a number of local Community Service Offices.

Medicaid is actually a complex system of programs, requirements and benefits. There are many different Medicaid programs for specific eligibility groups. In Washington, those groups are pregnant women, children, disabled individuals and persons over the age of 65 ("the aged").

Listed on the next page are the main types of Medicaid programs offered to different categories of individuals. This chart is designed to provide you with a quick reference to these programs.

Due to the variety of eligibility requirements for different programs, DSHS recommends that you review your eligibility online at **http://fortress.wa.gov/dshs/maa/eligibility/index.html.** You can also talk to a customer service representative. Call 1-800-562-3022 to determine the location of the Community Service Office nearest you.

## Healthy Options

Healthy Options is the name of the Medicaid managed care program. Under Healthy Options, a consumer is enrolled in a health plan and needs to have a Primary Care Provider (PCP). Consumers need referrals for specialist care.

Unless you receive SSI, Medicare, or qualify for an "exemption" from Healthy Options, Medicaid recipients must enroll if they are:

- a parent or relative caring for a child or children, or
- a child under age 19, not in foster care, or
- pregnant.

## Medicaid programs

| Medicaid Program | Eligibility |
|---|---|
| Categorically Needy Program (CN) | Aged, blind, disabled, pregnant women, and children who meet income requirements. |
| Medical Care Services (MCS) | Provides limited benefits to persons eligible for the Alcohol and Drug Addiction and Treatment and Support Act. |
| Long Term Care and Community Options Program Entry System (COPES) | Persons who are in need of (or at risk of) being institutionalized in a nursing home (must meet financial guidelines). |
| Alien Emergency Medical (AEM) | Children, parents with dependent children, and disabled adults who are ineligible for other Medicaid programs due to immigration status. |

## Exemptions from enrollment:

An exemption from Healthy Options can allow consumers to get medical care from their choice of providers who take medical coupons, without being limited to a single plan or PCP. You may qualify for an exemption if you:

- have good reason why care is not reasonably available under any plan. For example, the plan cannot meet a specialized health care need (and it is documented by the current provider);
- are pregnant and already being seen by another provider who is not in a plan;
- are homeless;
- have a provider who is not in a plan, and disrupting the treatment plan might be harmful to your health;
- have a hardship getting care from a plan because of distance or travel time;
- already have a provider who speaks your first language and cannot find a provider in the plan who does;
- are a Native American or Alaska Native, in which case you are automatically exempt and are only enrolled in Healthy Options if requested;
- have managed care coverage through medical insurance other than Medicaid.

You may request an exemption by calling **1-800-562-3022**, or by contacting your DSHS caseworker. It is best to submit a written request with supporting medical or other evidence.

If DSHS denies the exemption, they must send you a notice explaining the reasons and your right to a fair hearing.

For more information on Medicaid and Healthy Options, you can go to **www.cms.hhs.gov/medicaid/consumer.asp** or **http://fortress.wa.gov/dshs/maa/healthyoptions.**

## Washington State Health Insurance Pool (WSHIP)

As stated earlier in the discussion of health screening in the individual market (page 5), the Washington State Health Insurance Pool (WSHIP) provides health insurance for people who are unable to obtain individual coverage in the private marketplace. This plan provides comprehensive coverage, including a prescription drug benefit. Premiums are based on age and type of plan selected.

You are only eligible for this plan if you have failed the health screen for individual coverage (see page 5). If you do fail the health screen, the carrier you applied to will automatically send you an application for WSHIP.

There are two WSHIP options available for people who are **not** on Medicare:

- The Standard Plan (Plan 1), which is fee-for-service, allows you to go to the doctor of your choice;
- The Network Plan (Plan 3) uses providers from the First Choice network.

WSHIP also has a separate plan that is only available for people on Medicare (Plan 2.) This plan has different eligibility criteria.

In the fee-for-service plan, rates are set at 150% of the average market rate for comparable commercial coverage. Rates for the network plan (managed care) are 125% of the average market rate.

Some discount rates will be given to people age 50-64 with low income, people who have been continuously insured with their previous plan, and people who have been in WSHIP for more than three years. For further information about WSHIP, contact the administrator, BMI at: 1-800-877-5187 or **www.wship.org**.

# Coverage for kids

More than 100,000 children and teenagers in Washington state are without health insurance. However, there are several insurance programs available especially for children.

## Basic Health Plus

Basic Health Plus is a Medicaid program for children in low-income households. There are no copayments for services and no monthly premium; DSHS pays the cost of coverage. It offers added benefits and services for children, including vision and dental benefits, and transportation to medical services. If you are on Basic Health, your children may be eligible for Basic Health Plus. They must be under age 19 and U.S. citizens, or legal residents who arrived in the U.S. before Aug. 22, 1996. Children not living in your household may be enrolled in Basic Health (see page 6) but not Basic Health Plus. For more information call 1-800-660-9840, or visit the Basic Health website at: **www.basichealth.hca.wa.gov.**

## Children's Health Insurance Program (CHIP)

Children's Health Insurance Program (CHIP) is a federal/state program that covers children under age 19 in families whose income is too high for Medicaid and Basic Health, but below 250% of the Federal Poverty Level (FPL). Many children who don't qualify for Basic Health are eligible for CHIP. A family must meet income limits to qualify for CHIP. These income limits represent gross monthly household income minus childcare and other approved deductions.

While CHIP is technically not a Medicaid program, it is administered by the same state government office (Department of Social and Health Services) as Medicaid programs. When consumers apply for CHIP, the children are considered for Medicaid first. If the children are not eligible for Medicaid because of income, DSHS will then check to see if the family income fits within the CHIP income guidelines. If children are eligible for Medicaid, they are not eligible for CHIP. This program has no resource limits.

For more information about CHIP, go to **http://fortress.wa.gov/dshs/maa/chip** or call toll-free at 1-877-543-7669.

# Section 2

# Gaining and Maintaining Control of Your Health Insurance

This section is concerned with obtaining and then effectively managing and using your health care coverage and provider relationships. It will help you choose wisely and be a savvy consumer once you have coverage, to get the most out of what you have. It can also help you decide if what you have is right for you.

## Tips: checking out a plan

Make certain that the coverage you buy fits your needs, and that you receive the best price for the coverage. Your investigation should never be based on rates alone. Be sure to compare benefits as well. Look at two or three different plans, and be sure to compare them against your needs as well as to one another.

✓ **Benefits:** Be sure you understand the benefits as they are listed. Look at what will **not** be covered by the contract, not just what will be.

✓ **Limitations and exclusions:** Find out if there are special requirements for obtaining benefits. Example: Do you need prior authorization for some services, and how do you obtain that authorization? Are there waiting periods before coverage goes into effect?

✓ **Claims:** Before you buy, make sure you understand how to file a claim, where to send it, and how you will collect.

✓ **Costs:** Premiums for health insurance will vary greatly because there are no standard plans. When you look at bids from several companies, you will also need to look carefully at the benefits offered.

## Tips: checking out an agent

✓ **Many people buy health insurance** from agents who may represent only one or a number of licensed companies. Others may buy directly from companies themselves. Some companies sell their policies by mail; others may have offices that insurance purchasers can visit.

✓ **Agents earn a commission on your business** and should do more than just sell you a policy. They should answer your questions. Do not hesitate to ask your agent about your insurance problems.

✓ **If you need additional information,** contact the company that provides your coverage. You are the customer, and they should respond to you.

✓ **Never deal with an unlicensed agent.** Ask to see his or her license. Companies also must be licensed. You can check on any company or insurance representative's licensed status by calling the Insurance Consumer Hotline toll-free at 1-800-562-6900.

✓ **Never let yourself be pressured** by any insurance sales representative. You have the right to look at any policy before you buy it. Never buy because of a threat that "this coverage won't be available tomorrow." Report any inappropriate behavior to the Insurance Commissioner's investigators at www.insurance.wa.gov or call 1-800-562-6900.

✓ **Never buy an insurance policy you do not understand.** Ask to see the benefits explained in writing — in simple terms. Be sure to keep that piece of paper with the policy after you buy it.

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✓ **If you speak a language that the insurance agent cannot understand,** make sure that you arrange for an adult translator to accompany you.

✓ **Never give any insurance representative money** or a check without getting a receipt.

## Tips: checking out a company

Before you buy health coverage, find out about the company selling the plan. Here are key factors to consider:

✓ **Customer service.** Find out how the company services its policyholders. Does the company have a toll-free customer service number?

✓ **Complaint history.** Has the company had an unusually high number of consumer complaints? Check with our Insurance Consumer Hotline at **1-800-562-6900.**

✓ **Licensing status.** Make sure the insurance company is licensed to do business in Washington state. Call our Insurance Consumer Hotline to check a company's status at **1-800-562-6900**.

✓ **Financial stability.** Financial stability helps ensure that a company can pay its claims. In addition, Washington state law establishes requirements that each company must follow, and insurers are continually monitored by the Office of the Insurance Commissioner to make sure they are financially stable. Independent organizations also rate the financial stability of insurance companies. Your public library's reference desk may have published ratings from these sources.

## "Free Look"

- When you receive your new policy, be sure to read it carefully.
- Every individual health care insurance policy sold in the state of Washington has a 10-day "Free Look" period.
- If you are not satisfied for any reason, you may return the policy to the company or agent. The policy will then be voided and you may obtain a full refund of your premium.
- Keep your previous coverage until you have reviewed your new policy to ensure continuous coverage.
- Information on the "Free Look" period will be printed or attached to the face sheet of your policy.

# Questions to ask:

- What type of plan are you purchasing? (i.e. state sponsored, group, self funded, individual, association).
- What does the plan pay for and what does it exclude? Look in particular for preventive care, immunizations, well-baby care, substance abuse, organ transplants, durable medical equipment, alternative or chiropractic care.
- Does the plan have mental health benefits?
- Will the plan pay for long-term physical therapy?
- How much do you have to pay when you receive health care services, or how much is the co-payment or deductible? How often do you have to pay the co-payment or deductible (per year, per occurrence?)
- Are there limits on how much you must pay for health care services you receive (out-of-pocket maximums)? Are there maximums per year, per occurrence?
- Are there limits on the number of times you may receive a service (lifetime maximums, daily or annual benefit caps)?
- Has the company had an unusually high number of consumer complaints?
- What happens when you call the company's consumer complaint number?
- How long does it take to reach a real person?
- Will the plan pay for prescriptions? If so, what is the maximum benefit?
- Is your favorite doctor or other health care professional part of the carrier's network?
- Will you be able to choose your Primary Care Provider (PCP)? If you don't like her or him, what recourse will you have?
- How will you get access to specialists?
- What do the carriers consider to be urgent and emergency care?
- What treatments are considered "experimental" and therefore not covered?
- Does the plan have a "non-duplication of benefits" clause? If not, how does it coordinate benefits with other plans?
- What options will you have if you disagree with the treatment plan?

# Complementary and alternative providers

Washington state law requires state-regulated insurers to cover services provided by all of the state's licensed categories of health care providers including, but not limited to, chiropractors, medical doctors, acupuncturists, naturopaths, physician assistants, registered nurses, podiatrists, nurse midwives and massage therapists.

Most managed care plans restrict enrollees to providers in their own network, and may require a visit to your primary care provider for a referral.

Carriers are obligated to provide adequate networks containing every category of provider so that you have the full range of options the law requires. Also, the condition must be covered by your policy and its treatment must fall into the particular provider's scope of practice.

This law applies to all state-regulated plans. It does not apply to self-funded employer plans or union trusts, which are exempt from state regulation under federal law.

# Filing claims

## Things to do before you file a claim:

- **Review your policy or employee booklet** carefully to be sure the service in question is covered. If you have any reason to think that a health care service may not be covered, or that your carrier may not agree with your interpretation of the policy, talk it over first with your provider and with the insurance carrier. Resolving questions first can prevent complications later on.
- **Most managed care systems** only require you to make a co-payment, so you may not have to handle any significant paperwork for a covered service. But don't assume a treatment or service is covered. Follow your plan's rules, including pre-certification requirements and use of network providers.
- **Fill out any claim forms** the provider or carrier gives you, including your policy number and other identifying information.

## How to submit a claim yourself:

- **Find out if your provider submits** the claim for you or if you need to do it.
- **If you need to do it,** review the information to be sure it is complete and correct.
- **File the claim** as soon as you get the bill from the provider.
- **Send it** to the correct address.
- **Keep a copy** for your reference.
- **Wait for your carrier's statement** before you pay your provider directly.
- **Allow reasonable time** for the company to process your claim. The company must inform you if it needs any additional information to complete the claim. Sometimes, it will request additional information directly from the providers; in other cases, it will return the claim form to you to get more information.
- **If the carrier denies your claim,** it must send you an explanation of benefits that explains its decision.

## If your claim is denied:

- **The reason for denial** should be stated on your explanation of benefits.
- **If you disagree with the basis stated for denial,** check your policy or employee booklet for the company's appeal procedures.
- **The company should be able to answer** procedural questions about appeals over the phone. Call the carrier's assistance line (the telephone number should be listed on your statement).
- **Your appeal should be in writing** and may require information from your doctor.
- **Remember that you may be responsible for co-paymants** on some services and/or prescriptions.

# Getting help

You have rights as a health insurance consumer, and should understand what they are and how to exercise them.

## Patient Bill of Rights

The Patient Bill of Rights was passed by the Washington State Legislature in 2000 to ensure that patients covered by health plans receive quality care designed to maintain and improve their health, including sufficient and timely access, and adequate choice of health care providers. It outlines procedures to ensure that patients:

- **Are assured that health care decisions** are made based on appropriate medical standards;
- **Have better access** to information regarding their health insurance plans;
- **Have access to a quick and impartial process** for appealing denials of coverage;
- **Have the right** to independent third-party reviews of denials;
- **Are protected** from unneeded invasions of their privacy, and;
- **Can seek redress for damages** that result when managed care insurers withhold or deny appropriate care.

These provisions took effect on July 1, 2001, or on the date of the insurance policy's renewal. For more information on these provisions, see the OIC's Patient Bill of Rights factsheet, available on the OIC website at **www.insurance.wa.gov** or call our Insurance Consumer Hotline at **1-800-562-6900**.

## Other rights

- **Employer plans:** If your plan is a "self-funded" benefit offered by an employer, or by a bona fide union trust under a union contract, the state is prohibited under federal law from jurisdiction. Instead, you may file a complaint with the U.S. Department of Labor (DOL) Employee Benefits Security Administration (**1-866-444-3272**). The DOL does not interpret provisions of any particular health plan or require employers to pay claims, but may investigate your complaint. In some disputes, the DOL may suggest personal legal advice as your best option.
- **Government/church plans:** If the plan is self-funded, but offered through a government or church employer, follow the appeals procedures outlined in your benefit booklet and other plan documents. In most cases, ultimate responsibility for resolving these disputes rests with the governing body of the employer sponsoring the plan, such as a school board.
- **The disabled:** If you have a disability, you may have special protections available under the Americans with Disabilities Act (ADA) that apply specifically to self-funded coverage. You can reach the ADA Technical Assistance Center at **1-800-949-4232** or the U.S. Department of Justice at **1-800-514-0301** (voice) or **1-800-514-0383** (TDD).

# Filing a complaint with the Commissioner

If you're unable to resolve a dispute with your company or agent and still believe you have a valid case, contact the Insurance Consumer Hotline at **1-800-562-6900.** The OIC investigates consumer complaints at no cost. To speed processing of your inquiry or complaint:

- **Call the Hotline first** to talk to a health insurance expert about your problem and gather any pertinent information. You also can request that a copy of the OIC complaint form be mailed to you. The form is also available on the OIC website at **www.insurance.wa.gov.**
- **Use the form to briefly state your case,** but provide complete information. Be sure to include:
  - ✓ Name of your insurance carrier
  - ✓ Policy number
  - ✓ Name of the agent or adjuster involved
  - ✓ Name of your employer, if the plan is through your employer

**Also be sure to sign the medical release on the back of the form.**

- **Include photocopies** of any documentation that supports your case.
- **Explain what has been done to address** your dispute, including who you talked to and what you were told.

The Insurance Commissioner's compliance analysts will investigate your complaint and keep you advised of what has happened. If the insurer has erred, the compliance analyst will work on your behalf to have the situation corrected.

**The Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine** is also a free resource available to you through the OIC. Highly trained volunteer counselors can educate you about your options, assist you with paperwork or other issues, and advocate on your behalf. Call **1-800-562-6900**.

## Hotlines, organizations & individual plans

### Washington State Office of the Insurance Commissioner

For publications and help with questions and concerns about all types of insurance:
Insurance Consumer Hotline: 1-800-562-6900
or www.insurance.wa.gov

For education and assistance with health insurance and health care access issues, publications, and referral to a local counseling site:
SHIBA HelpLine: 1-800-562-6900 or
www.insurance.wa.gov/consumers/shiba/default.asp

### Centers for Medicare and Medicaid Services (CMS)

**Medicare Hotline**
**(800) MEDICARE** 1-800-633-4227
Local customer service: (206) 615-2345
Local service for Medicare Managed Care:
(206) 615-2351 or www.medicare.gov

### Washington State Health Care Authority

Public Employees Benefit Board (PEBB)
www.pebb.hca.wa.gov
Employee customer service 1-800-700-1555
Retiree customer service 1-800-200-1004
Basic Health customer service 1-800-660-9840
or www.basichealth.hca.wa.gov

### Federal Department of Health and Human Services

National Elder Care Locator Service:
1-800-677-1116 or www.eldercare.gov

### Federal Department of Labor - Employee Benefits Security Administration

Benefit advisors and publication hotline:
1-866-444-3272 or www.dol.gov

### Washington State Health Insurance Pool (WSHIP)

An assigned risk pool open to any Washington resident turned down for individual coverage. WSHIP also is the agency that designed and supervised the health screen mandated by the 2000 Legislature. 1-800-877-5187
or www.wship.org

### Federal Social Security Administration

Customer service 1-800-772-1213
or www.socialsecurity.gov

## For additional help with health insurance issues:

Consult with a volunteer counselor from the Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine. SHIBA HelpLine is a statewide network of trained volunteers who educate, assist, and advocate for consumers regarding health insurance and health care access. Volunteer counselors are impartial and highly trained by the Insurance Commissioner's office, and the service is **FREE**. To be referred locally, call 1-800-562-6900.

WASHINGTON STATE OFFICE OF THE INSURANCE COMMISSIONER'S
TOLL-FREE HOTLINE

# Insurance Consumer HOTLINE

We're here to help you!

Call:

## 1-800-562-6900

TDD: 1-360-586-0241

ALL of your insurance questions answered with one easy phone call!

This **FREE** service is staffed by trained experts who are ready to **IMMEDIATELY** assist you by answering any of your insurance questions, ordering any of the OIC's many publications, and getting bilingual help if necessary.

## Give us a call today!

STATEWIDE HEALTH INSURANCE BENEFITS ADVISORS (SHIBA) HELPLINE is a statewide network of trained volunteers who educate, assist and advocate for consumers regarding health insurance, health care access, and prescription access, so they know their rights and can make informed decisions.

*This publication may have been partially funded by grants from the Centers for Medicare & Medicaid Services and the US Administration on Aging.*

Call our Insurance Consumer Hotline

**1-800-562-6900**

See inside back cover for details

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